Reproductive Health Services

How Does the Department Define Reproductive Health Services? [WAC 388-532-001]

The Department defines reproductive health services as those services that:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

Provider Requirements [Refer to WAC 388-532-110]

To be paid by the Department for reproductive health services provided to eligible clients, physicians, and advanced registered nurse practitioners (ARNPs) must:

- Meet the requirements in Chapter 388-502 WAC *Administration of Medical Programs - Providers*;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

See the *Department-Approved Family Planning Providers Billing Instructions* for more information on how to become a Department-approved family planning provider and more information on the Family Planning Only program. Clients enrolled in a Department managed care organization may self refer outside their plan for abortions.

Who Is Eligible? [Refer to WAC 388-532-100(1)]

The Department covers limited, medically necessary reproductive health services for clients who are on a Benefit Service Package (BSP) that covers reproductive health services.

> **Note:** Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Family Planning Only clients are **only** eligible to receive services that are related to the prevention of unintended pregnancy and for sterilizations. They are **not** eligible for other reproductive health services that include maternity care and abortion.

Limited Coverage:

- The Department covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.
- The Department pays only Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary clients.

What Services Are Covered? [Refer to WAC 388-532-120]

Services for Women

- **A routine gynecological examination (G0101) (cervical, vaginal, and breast screening examination),** is allowed once per year as medically necessary when billed with one of the following diagnosis codes:

  ✓ V72.31 routine gynecological exam with pap cervical smear;
  ✓ V76.47 routine vaginal pap smear; or
  ✓ V76.2 cervical pap smear without general gynecological exam.

  If it is necessary to see the client on the same day for a medical problem, you may bill using the appropriate E&M code (99201 – 99215) with a separately identifiable diagnosis using modifier 25. **Note:** The Department will not pay for two E&M visits on the same day.

  Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

  Note: The Department does not pay for preventive health exams for clients 21 years of age and older.

- **FDA-approved prescription contraception method**
  (see the Department/MPA *Prescription Drug Program Billing Instructions*;

- **OTC contraceptives, drugs, and supplies**
  (see the Department/MPA *Prescription Drug Program Billing Instructions*);

- **Maternity-related services;**

- **Abortions;**

- **Sterilization procedures when:**

  ✓ Requested by the client; and
  ✓ Performed in an appropriate setting for the procedure.

  Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Services for Women (continued)

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

  Note: For HIV testing use CPT® 86703. **The Department does not cover HIV testing and counseling for Family Planning Only clients.**

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence;

- **Screening mammograms (CPT 77057)** for clients 40 years of age and older, once per calendar year. Clients 39 years of age and younger require prior authorization (see section I).

- **Colposcopy** and related medically necessary follow-up services.

- **Emergency contraception (e.g., Plan B®)** – Providers may bill for emergency contraception medication under HCPCS J3490 with modifier FP. Please refer to the Department/MPA *MPA-Approved Family Planning Providers Billing Instructions* for details.

- **Implanon (HCPCS code J7307)**

  The Department pays for the contraceptive implant system, Implanon.

  To bill for Implanon, providers must:

  - Bill with ICD-9 Diagnosis V25.5;
  - Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
  - Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
  - Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
  - Enter the NDC in Box 19 on the CMS-1500 Claim Form and send in an invoice with your billing.

  Note: The Department pays for Implanon only once every three years, per client.

Services for Men

The Department covers the following reproductive health services for men:

- **Office visits** where the primary focus and diagnosis is contraceptive management (including vasectomy counseling) and/or where there is a medical concern;

- **OTC contraceptives, drugs, and supplies** (as described in the current Department/MPA *Prescription Drug Program Billing Instructions*);

- **Sterilization procedures when:**

  ✓ Requested by the client; and
  ✓ Performed in an appropriate setting for the procedure.

  Note: The physician's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

  Note: For HIV testing use CPT 86703.

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence; and

- **Prostate cancer screening** for men when ordered by a physician, physician assistant, or ARNP. See the *Billing and Claim Forms* section specifics.

  Note: The Department does not pay for preventive health exams for clients 21 years of age and older.

Physician Services Provided to Clients on the Family Planning Only Program

What Is the Purpose of the Family Planning Only Program?
[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows the 60-day post pregnancy coverage by the Department. **Men are not eligible for the Family Planning Only program.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Services Card. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Services Card.

Provider Requirements **[Refer to WAC 388-532-520]**

To be paid by the Department for services provided to clients eligible for the Family Planning Only program, physicians and advanced registered nurse practitioners (ARNPs) must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who Is Eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined eligible for a retroactive period (see the *Definitions & Abbreviations* section) covering the end of the pregnancy.

What Services Are Covered? [Refer to WAC 388-532-530]

> **Note:** All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series, excluding V25.3).

The Department covers the following services under the Family Planning Only program:

- **Cervical, vaginal, and breast cancer screening examination,** once per year as medically necessary. The examination must be:

  ✓ Provided according to the current standard of care; and
  ✓ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3).

- **FDA-approved prescription contraception methods**
  (see the Department/MPA *Prescription Drug Program Billing Instructions* for requirements)

- **OTC contraceptives, drugs, and supplies**
  (see the Department/MPA *Prescription Drug Program Billing Instructions*)

- **Sterilization** procedures that meet the requirements of the Department/MPA *Physician-Related Services Billing Instructions*, if it is:

  ✓ Requested by the client; and
  ✓ Performed in an appropriate setting for the procedure.

> **Note:** The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:

  ✓ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3); and

  ✓ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence.

- **Implanon (CPT code J7307)**

  The Department pays for the contraceptive implant system, Implanon.

  To bill for Implanon, providers must:

  ✓ Bill with ICD-9 Diagnosis V25.5;

  ✓ Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;

  ✓ Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;

  ✓ Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and

  ✓ Enter the NDC in Box 19 on the CMS-1500 Claim Form and send in an invoice with your billing.

  Note: The Department pays for Implanon only once every three years, per client.

What Drugs and Supplies Are Paid Under the Family Planning Only Program?

The Department pays for the following family planning-related drugs and contraceptives prescribed by a physician:

Absorbable Sulfonamides	Nitrofuran Derivatives
Anaerobic antiprotozoal – antibacterial agents	Oral contraceptives
Antibiotics, misc. other	Quinolones
Antifungal Agents	Tetracyclines
Antifungal Antibiotics	Vaginal Antibiotics
Cephalosporins – 1st generation	Vaginal antifungals
Cephalosporins – 2nd generation	Vaginal lubricant preparations
Cephalosporins – 3rd generation	Vaginal Sulfonamides
Condoms	
Contraceptives, injectables	
Contraceptives, intravaginal	
Contraceptives, intravaginal, systemic	
Contraceptives, transdermal	
Diaphragms/cervical caps	
Intrauterine devices	
Macrolides	

Drugs for Sterilizations

Antianxiety Medication – Before Sterilization Procedure

- Diazepam
- Alprazolam

Pain Medication – After Sterilization Procedure

- Acetaminophen with Codeine #3
- Hydrocodone Bit/ Acetaminophen
- Oxycodone HCl/Acetaminophen 5/500
- Oxycodone HCl/ Acetaminophen

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, sponge, etc.,) may also be obtained with a Medical ID Card in a 30-day supply through a pharmacy.

Contraceptive hormone prescriptions must be written for three or more months, with a maximum of 12 months, unless there is a clinical reason to write the prescription for less than three months.

> **Note:** All services provided to Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What Services Are N*ot* Covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and

- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

> **Note:** If the client is only covered by the Family Planning Only program but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope of care.

Inpatient Services: The Department does not pay for inpatient services under the Family Planning Only program. However, inpatient costs may be incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to the Department of the circumstances and conditions that caused the need for the inpatient services in order for the Department to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-04 Claim Form, CMS-1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to the Department. See the *Important Contacts* section.

Payment [Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: The Department limits payment under the Family Planning Only program to visits and services that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and

- Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Maternity Care and Delivery

Prenatal Assessments Are Not Covered

The Department does not cover prenatal assessments. If a client is seen for reasons other than routine antepartum or postpartum care, providers must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

Exception: Providers must bill E&M codes for antepartum care if ***only*** 1-3 antepartum visits are done, as discussed later in these billing instructions.

Confirmation of Pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, bill this visit using the appropriate level E&M code, if the obstetrical (OB) record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and must not be billed separately.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E&M code if the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

If the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated, bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (ICD-9-CM diagnosis code 626.8)]. Do not bill using the pregnancy diagnosis codes (e.g. V22.0-V22.2) unless the OB record is initiated at this visit. If the OB record is initiated at this visit, the visit is considered part of the global package.

Global (Total) Obstetrical (OB) Care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes all the following:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If the provider furnishes all of the client's antepartum care, perform the delivery, and provide the postpartum care, the provider **must bill** using one of the global OB procedure codes.

Use HCPCS code 0500F along with the appropriate billing code on the first prenatal visit. The Department is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Please note this date by entering HCPCS code 0500F with ICD-9-CM diagnosis codes V22.0-V22.2 on the claim.

When more than one provider in the same clinic (same group NPI) sees the same client for global maternity care, the Department pays only one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group NPI ***must not*** bill the Department the global (total) obstetrical care procedure codes. In this case, the OB services must be "unbundle" and the antepartum, delivery, or postpartum care must be billed separately.

Note: Do not bill the Department for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, providers may not be able to bill the Department for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as the Department may have paid another provider for some of the client's OB care, or a provider may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to a practice late in the pregnancy…

- If the client has had antepartum care elsewhere, the subsequent provider must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if the subsequent provider bills the global OB package, that provider is billing for some antepartum care that another provider has claimed.

- OR –

- If the client did not receive any antepartum care prior to coming to the provider's office, bill the global OB package.

  In this case, the provider may actually perform all of the components of the global OB package in a short time. The Department does not require this provider to perform a specific number of antepartum visits in order to bill for the global OB package.

If a client moves to another provider (not associated with the providers practice), moves out of the area prior to delivery, or loses the pregnancy…

When another physician has seen the client for part of the antepartum care and has transferred the client to you for care, and you are billing separately for the antepartum care you are delivering, enter "transfer of care" in field 19 of the CMS-1500 claim form.

Bill only those services you actually provided to these clients.

If a client changes insurance during her pregnancy…

Often, a client is fee-for-service at the beginning of her pregnancy and enrolled in a Department managed care organization for the remainder of her pregnancy. The Department is responsible for paying only those services provided to the client while she is on fee-for-service. The managed care organization pays for services provided after the client is enrolled with the plan.

The Department encourages early prenatal care and is actively enrolling new clients into the Healthy Options program. If a client is on fee-for-service and is enrolling in a Healthy Options plan at the beginning of her pregnancy, consider billing the first visit as a secondary confirmation of pregnancy using ICD-9-CM diagnosis code 626.8 with the appropriate level of office visit as described under the "Confirmation of Pregnancy" section.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. The provider must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, the Department considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a ***total*** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a ***total*** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill the Department using the date of the last antepartum visit in the "to and from" fields.

- If the client had a ***total*** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill the Department using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).
When billing for antepartum care, ***do not bill*** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the ***total*** number of times you saw the client for all antepartum care during her pregnancy, and ***may not*** be billed in combination with each other during the entire pregnancy period.

Note: Do not bill the Department until all antepartum services are complete. Hospital care for pregnant women can be billed concurrently.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill the Department using one of the following CPT codes:

- 59409 (vaginal delivery only);
- 59514 (cesarean delivery only);
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]; or
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)].

If a provider does not furnish antepartum care, but performs the delivery and provides postpartum care, bill the Department one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care);
- 59515 (cesarean delivery, including postpartum care);
- 59614 (VBAC, including postpartum care); or
- 59622 (attempted VBAC, including postpartum care).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill the Department using CPT code 59430 (postpartum care only).

If a provider furnishes all of the antepartum and postpartum care, but does not perform the delivery, bill the Department for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Postpartum care includes office visits for the six week period after the delivery and includes family planning counseling and contraceptive management.

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier UA.** The office visits may be billed in addition to the global fee ***only after*** exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. ***The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.*** **For example:**

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier UA, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. ***It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.***

Labor Management

Providers may bill for labor management ***only*** when another provider (outside of the first provider's group practice) performs the delivery. If a provider performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill the Department for the hospital admission or for labor management. These services are included in the global OB package.

If, however, a provider performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of the first provider's group practice) takes over delivery, the global OB package must be unbundled and the providers must bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill the Department for one of the hospital admission CPT **codes 99221-99223 with modifier TH**.

In addition to the hospital admission, the Department pays providers for **up to three hours** of labor management using prolonged services CPT **codes 99356-99357 with modifier TH**.

Payment for prolonged services is *limited to three hours per client, per pregnancy*, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management.

Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice.

> **Note**: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.
>
> **Note:** The Department pays for labor management only when the provider performs the above services on the same day.

High-Risk Deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, the Department pays providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code ***must clearly*** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only *ONE* line of service (e.g. 59400 TG) to receive payment for BOTH the delivery and the high-risk add-on. *DO NOT* bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.
A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99465, when appropriate.

Note: The Department **does not** pay an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Payment is limited to one per client, per pregnancy (even in the case of multiple births).

Consultations

If another provider refers a client during her pregnancy for a consultation, bill the Department using consultation CPT codes 99241-99245. If an inpatient consultation is necessary, bill using CPT codes 99251 – 99255 or for a follow-up bill using CPT codes 99231-99233. The referring physician's name and NPI must be listed in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), the Department pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill the Department the appropriate consultation code.

- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill the Department the appropriate **consultation code with modifier 57** (e.g. 99241-57).

The Department does not pay the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** the Department for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). The Department does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

The Department pays consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- The Department pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Payment for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- The Department pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.

- A physician or physician assistant certified (PA-C) may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Payment is 20% of the delivery-only code's maximum allowance.

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's NPI.

- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see the Anesthesia section in Section F of these billing instructions.

- For deliveries in a birthing center, refer to the current Department/MPA *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to the current Department/MPA *Planned Home Births Billing Instructions.*

Note: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, refer to the Department/MPA *Maternity Support Services/Infant Case Management Billing Instructions.*

HIV/AIDS Counseling/Testing

The Department covers one pre- and one post-HIV/AIDS counseling/testing session (CPT Code 99401) per client each time the client is tested for HIV/AIDS. **[Refer to WAC 388-531-0600]**

Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. The Department does not pay for counseling visits when billed with an E&M service on the same day.

Exceptions:

1) The client is being seen for a medical problem and modifier 25 is billed; or

2) The client is being seen for an antepartum visit and modifier TH is used.

The Department does not pay for a counseling visit if the client is being seen only to confirm pregnancy and an office visit is billed, because the counseling is considered part of the office visit.

The Department covers HIV testing (86701-86703) for pregnant women when billed with the following diagnosis codes: V22.0, V22.1, V22.2, or V28.89.

For your convenience, a table summarizing "Billing the Department for Maternity Services" is included on the following pages.

Global (Total) Obstetrical (OB) Care

Service	Procedure Code/Modifier	Summary of Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Total OB care, vaginal delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple bills must be billed with the appropriate delivery-only code.
	59510	Total OB care, c-section	
	59610	Total OB care, VBAC	
	59618	Total OB care, attempted VBAC	

Antepartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill ***only one*** of these codes to represent the total number of times you saw the client for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Modifier TH must be billed.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
Delivery only	59409	Vaginal delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
	59514	C-Section delivery only	
	59612	VBAC delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Vaginal delivery including postpartum care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
	59515	C-Section delivery with postpartum care	
	59614	VBAC including postpartum care	
	59622	Attempted VBAC including postpartum care	

Postpartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Postpartum care only	59430	Postpartum care only	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Additional Monitoring for High-Risk Conditions

Service	Procedure Code/Modifier	Summary of Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 UA	Office visits with OB service modifier	Must not be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits; must be billed with modifier UA.

Labor Management

Service	Procedure Code/Modifier	Summary of Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Hospital admit services with OB services modifier	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; **must not be billed by delivering provider**. Admit code with modifier TH and the prolonged services code(s) **must be billed on the same claim form.**
	+99356 **Limited to 1 unit**	Prolonged services, inpatient setting, 1st hour	
	+99357 **Limited to 4 units**	Prolonged services, inpatient setting, each add'l 30 minutes	

High-Risk Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
High-risk delivery *[Not covered for assistant surgeons, co-surgeons, or RNFA]*	Add modifier TG to the delivery code (e.g. 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only **ONE** line of service (e.g. 59400 TG) for **BOTH** the delivery and high-risk add-on.

Sterilization

What Is Sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

> **Note:** The Department does **not** pay for hysterectomies performed solely for the purpose of sterilization.

What Are the Department's Payment Requirements for Sterilizations? [Refer to WAC 388-531-1550(2)]

The Department covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

> **Note:** The Department pays providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

The Department pays providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for a sterilization procedure only when the completed federally approved Sterilization Consent Form, DSHS 13-364, is attached to the claim. Click link to download the DSHS 13-364 http://www1.dshs.wa.gov/pdf/ms/forms/13_364.pdf. The Department does not accept any other forms attached to the claim. The Department pays after the procedure is completed.

The Department pays providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. The Department determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before the Department will pay the provider for the sterilization of a mentally incompetent or institutionalized client. The Department requires both of the following to be attached to the claim form:

- Court orders that include the following:
  - ✓ A statement that the client is to be sterilized; **and**
  - ✓ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent Form, DSHS 13-364, signed by the client's legal guardian.

When Does the Department Waive the 30-Day Waiting Period? **[WAC 388-531-1550(3) and (4)]**

The Department does not require the 30-day waiting period, but does require at least a 72 hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

The Department waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent Form, DSHS 13-364. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**CMS-1500 Claim Form field 19:** *"NOT ELIGIBLE 30 DAYS BEFORE DELIVERY"*); or
- The client did not obtain medical care until the last month of pregnancy (**CMS-1500 Claim Form field 19:** *"NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**CMS-1500 Claim Form field 19:** *"NO SUBSTANCE ABUSE AT TIME OF DELIVERY."*)

The provider must note on the CMS-1500 Claim Form in field 19 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically must indicate this information in the *Comments* field.

When Does the Department *Not* Accept a Signed Sterilization Consent Form? [Refer to WAC 388-531-1550(5) and (6)]

The Department does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why Do I Need a Department-Approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form, DSHS 13-364, is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form, DSHS 13-364, to attach to their claim.

Providers must use Sterilization Consent Form, DSHS 13-364, in order for the Department to pay your claim. **The Department does not accept any other form**.

> To **download** DSHS forms, visit: http://www1.dshs.wa.gov/msa/forms/eforms.html
> Scroll down to form number 13-364.

The Department will deny a claim for a procedure received without the Sterilization Consent Form, DSHS 13-364. The Department will deny a claim with an incomplete or improperly completed Sterilization Consent Form. Submit the claim and completed Sterilization Consent Form, DSHS 13-364, to the Department (see *Important Contacts*):

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent Form, DSHS 13-364, is being sent. Then send in the form with the electronic claims ICN.

Who Completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does the Department waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.

- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.

- If sections I, II, and III of the initial Sterilization Consent Form are completed by one physician or group, and a different physician or group performed the surgery:

  ✓ The physician performing the surgery completes another Sterilization Consent Form filling in section IV; and

  ✓ The client signs and dates lines (7) and (8) of Section I. The client's date of signature can be the date of surgery or after. It does not have to be the date of the procedure.

  Submit both Sterilization Consent Forms with your claim.

Frequently Asked Questions on Billing Sterilizations

1. **If I provide sterilization services to Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?**

   The scope of coverage for Family Planning Only clients is limited to contraceptive intervention only. The Department does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

   Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

   Note: Remember to submit all sterilization claims with the **completed,** federally approved Sterilization Consent Form.

2. **If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or Cesarean Section delivery, how do I bill?**

   CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form for payment.

   If the provider does not have the consent form or it wasn't completed properly or the client was sterilized prior to the 30 days waiting period (client doesn't meet the criteria for the Department to waive the 30 day waiting period) then the sterilization line on the claim will be denied and the other line items on the claim will be processed for possible payment.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent Form, DSHS 13-364, must be legible.
- All blanks on the Sterilization Consent Form, DSHS 13-364, must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- The Department does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form, DSHS 13-364:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over. *Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.*
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent Form, DSHS 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn't have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent Form, DSHS 13-364. Must be signed in ink.

Section I: Consent to Sterilization	
Item	**Instructions**
8. Month/Day/Year:	Date of consent. Must be date that client was initially counseled regarding sterilization. Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). **Note**: This is true even of shorter months such as February. The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8. Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005. If less than 30 days, refer to "When does the Department waive the 30 day waiting period?" and section IV of Sterilization Consent Form, DSHS 13-364.
Section II: Interpreter's Statement	
Item	**Instructions**
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be interpreter's original signature in ink.**
11. Date:	Must be date of interpreter's statement.
Section III: Statement of Person Obtaining Consent	
Item	**Instructions**
12. Name of individual:	Must be client's first and last name. Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	**Instructions**
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent Form, DSHS 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to "When does the Department waive the 30 day waiting period?" and section IV of the Sterilization Consent Form, DSHS 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who **actually** performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form, DSHS 13-364.
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

    a. Section I: Consent to Sterilization: **"I am at least 21…"**
    b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**
    c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 18 years of age and was born on (3) **August 1, 1984**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☒ Asian or Pacific Islander
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

Hysterectomies [Refer to WAC 388-531-1550(10)]

- Hysterectomies are paid only for medical reasons ***unrelated*** to sterilization.

- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed Department-approved consent form to attach to their claim.

- **ALL** hysterectomy procedures require a properly completed Department-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.

- Submit the claim and completed Department-approved consent form (see *Important Contacts* section).

Download the Hysterectomy Consent Form, DSHS 13-365, at:

http://www1.dshs.wa.gov/msa/forms/eforms.html

Abortion Services (Drug Induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions.

  ✓ J9260 Methotrexate sodium, 50 mg
  ✓ S0191 Misoprostol, oral, 200 mcg

- When these drugs are used for abortion services, providers must bill using the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be billed on the same claim as the abortion drugs.

- Rho(D) immune globulin must be billed using the appropriate HCPCS codes.

- **RU-486 Abortion Drug**

  The Department pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful termination must be billed on the same claim form as the abortion drugs.

Bill HCPCS Code	Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion centers (non hospital-based) must be approved by the Department to be able to bill for facility fee payments. To become an abortion center provider, fax a request to the program manager at 1-360-586-1471.

Abortion Center Contracts (Facility Fees)

For providers who currently have an abortion center contract with the Department, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention. The Department pays the contractor facility fees for surgical abortion services once per abortion, per eligible client. Clients on the Family Planning Only program are not eligible for abortions. Please refer them to their local Community Service Office to request a change in their eligibility since they are pregnant. Clients enrolled in a Department managed care organization can self refer for abortions.

Contracted facility fee payment includes all room charges, equipment, supplies, and drugs (including anti-anxiety, antibiotics, and pain medications, but excluding Rho(D) immune globulins). **Payment is limited to one special agreement facility fee per client, per abortion.** The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete. The facility fee does not include professional services, lab charges, or ultrasound and other x-rays, which can be billed separately.